## Appendix 5
## Conversion of Therapy Treatment Time to Wisconsin Medicaid Treatment Units for Billing Purposes

The following charts illustrate the calculation of units of time for billing face-to-face occupational therapy services.

CONVERSION TABLE 1
Treatment Time to Treatment Units for Procedure Codes Referencing "15 Minutes of" in the Procedure Code Description

| **Actual Treatment Time** (in minutes) | **Treatment Unit(s) Billed** |
|---|---|
| 7.5 | 0.5 |
| 15.0 | 1.0 |
| 22.5 | 1.5 |
| 30.0 | 2.0 |
| 37.5 | 2.5 |
| 45.0 | 3.0 |

CONVERSION TABLE 2
Treatment Time to Treatment Units for Procedure Codes Referencing "30 Minutes of" in the Procedure Code Description

| **Actual Treatment Time** (in minutes) | **Treatment Unit(s) Billed** |
|---|---|
| 15.0 | 0.5 |
| 30.0 | 1.0 |
| 45.0 | 1.5 |
| 60.0 | 2.0 |
| 75.0 | 2.5 |
| 90.0 | 3.0 |

## Appendix 6
## List of Evaluations, Tests, and Measures

An evaluation consists of one or more tests or measures used in assessing a recipient's needs. A written report of the evaluation results must accompany the test chart/form in the recipient's medical record.

Evaluations are counted toward the 35-day spell of illness prior authorization threshold.

The following list includes tests and measures which may be used in an evaluation:

1. Motor skills include the following:
   - Range-of-motion.
   - Gross muscle test.
   - Manual muscle test.
   - Coordination evaluation.
   - Nine-hole peg test.
   - Purdue pegboard test.
   - Strength evaluation.
   - Head-trunk balance evaluation.
   - Standing balance-endurance.
   - Sitting balance-endurance.
   - Prosthetic balance.
   - Hemiplegic evaluation.
   - Arthritis evaluation.
   - Hand evaluation-strength and range of motion.
2. Sensory integrative skills include the following:
   - Beery test of visual motor integration.
   - Southern California kinesthesia and tactile perception test.
   - Milloni-Comparetti developmental scale.
   - Gessell developmental scale.
   - Southern California perceptual motor test battery.
   - Marianne Frostig developmental test of visual perception.
   - Reflex testing.
   - Ayres space test.
   - Sensory evaluation.
   - Denver developmental test.
   - Perceptual motor evaluation.
   - Visual field evaluation.
3. Cognitive skills include the following:
   - Reality orientation assessment.
   - Level of cognition evaluation.
4. Activities of daily living skills include the following:
   - Bennet hand tool evaluation.
   - Crawford small parts dexterity test.
   - Avocational interest and skill battery.
   - Minnesota rate of manipulation.
   - ADL evaluation-men and women.
5. Social interpersonal skills-evaluation of response in group.
6. Psychological intrapersonal skills include the following:
   - Subjective assessment of current emotional status.
   - Azima diagnostic battery.
   - Goodenough draw-a-man test.
7. Therapeutic adaptations.
8. Environmental planning, environmental evaluation.

## Appendix 7
## List of Procedures

Covered occupational therapy treatment procedures are the services listed on this page. If they are medically necessary, their services include, but are not limited to, the following:

√ Motor skills.

√ Sensory integrative skills.

√ Cognitive skills.

√ Activities of daily living skills.

√ Social interpersonal skills.

√ Psychological intrapersonal skills.

√ Preventive skills.

√ Therapeutic adaptations.

√ Environmental planning.

A complete description of covered occupational therapy services is included in *Wisconsin Medicaid Provider Updates*. These *Updates* list billable services by procedure code. Refer to Appendix 4 of this handbook for a current list of procedure codes.

## Appendix 8
## Sample Prior Authorization Request Form for Occupational Therapy Services

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 0750456

1 PROCESSING TYPE: 111

| | |
|---|---|
| 2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890 | 4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow St. Anytown, WI 55555 |
| 3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient, Im A. | |
| 5 DATE OF BIRTH: MM/DD/YY (Child) | 6 SEX: M ☐ F ☒ |
| 8 BILLING PROVIDER TELEPHONE NUMBER: ( xxx ) xxx-xxxx | |
| 7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE: I.M Billing 1 W.Williams Anytown, WI 55555 | 9 BILLING PROVIDER NO. 87654300 |
| | 10 DX: PRIMARY: 343.9 C.P. |
| | 11 DX: SECONDARY |
| | 12 START DATE OF SOI: / 13 FIRST DATE RX: |

| 14 PROCEDURE CODE | 15 MOD | 16 POS | 17 TOS | 18 DESCRIPTION OF SERVICE | 19 QR | 20 CHARGES |
|---|---|---|---|---|---|---|
| Q0110 | OT | 3 | 1 | Re-evaluation | 01 | xxxx |
| 97535 | OT | 3 | 1 | Activities of daily living (each 15 min.) | 40 | xxxx |
| 97112 | OT | 3 | 1 | Kinesthetic sense, balance, proprioception | 40 | xxxx |
| | | | | (each 15 min.) | | |
| 97770 | OT | 3 | 1 | Sensory integrative (each 15 min.) | 40 | xxxx |
| | | | | | | |
| *Each session will include a combination of codes totalling 45 minutes. | | | | | | |
| | | | | | TOTAL CHARGE | 21 xxxx |

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY (DATE) 24 I.M. Provider, O.T.R. Please begin P.A. XX/XX/XX (REQUESTING PROVIDER SIGNATURE)

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

☐ MODIFIED – REASON:

☐ DENIED – REASON:

☐ RETURN – REASON:

DATE _____ CONSULTANT/ANALYST SIGNATURE _____

482-120

## Appendix 8a
## Prior Authorization Request Form Completion Instructions
## (Occupational Therapy)

* See Appendix 10a of this handbook for Spell of Illness PA/RF instructions.

### Element 1 - Processing Type
Enter processing type 111, occupational therapy.

### Element 2 - Recipient's Wisconsin Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's current identification card.

### Element 3 - Recipient's Name
Enter the recipient's last name, first name, and middle initial from the recipient's current identification card.

### Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, include the name of the nursing home or facility.

### Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41) from the recipient's current identification card.

### Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

### Element 7 - Billing Provider's Name, Address, and Zip Code
Enter the billing provider's name and complete address (street, city, state, and zip code). *No other information should be entered in this element since it also serves as a return mailing label.*

### Element 8 - Billing Provider's Telephone Number
Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

### Element 9 - Billing Provider's Wisconsin Medicaid Provider Number
Enter the billing provider's eight-digit provider number.

### Element 10 - Recipient's Primary Diagnosis
Enter the appropriate International Classification of Disease, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis *code and description most* relevant to the service/procedure requested.

### Element 11 - Recipient's Secondary Diagnosis
When there is a secondary diagnosis, enter the appropriate ICD-9-CM diagnosis *code and description* additionally descriptive of the recipient's clinical condition.

### Element 12 - Start Date of Spell of Illness
Do not complete this element *unless* requesting a therapy (PT, OT, speech) spell of illness. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

### Element 13 - First Date of Treatment
Do not complete this element *unless* requesting a therapy (PT,OT, speech) spell of illness. Enter the date of the first

treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

### Element 14 - Procedure Code(s)

Enter the appropriate HCFA Common Procedure Coding System (HCPCS) procedure code as described in the plan of care in this element.

### Element 15 - Modifier

Enter the "OT" modifier appropriate for each procedure code.

### Element 16 - Place of Service

Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

| Code | Description |
|---|---|
| 0 | Other |
| 3 | Office |
| 4 | Home |
| 7 | Nursing Facility |
| 8 | Skilled Nursing Facility |

### Element 17 - Type of Service

Enter the appropriate type of service code for each service/procedure/item requested. *Do not complete* this element if requesting a therapy (occupational therapy) spell of illness.

| Numeric | Description |
|---|---|
| 1 | Medical |
| 9 | RehabilitationAgency |

### Element 18 - Description of Service

Enter a written description corresponding to the appropriate HCPCS procedure code for each service/procedure requested.

### Element 19 - Quantity of Service Requested

Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure requested.

### Element 20 - Charges

Enter your usual and customary charge for each service/procedure requested. If the quantity is greater than "1," multiply the quantity by the charge for each service/procedure requested. Enter that total amount in this element.

*Note:* The charges indicated on the *request form* should reflect the provider's usual and customary charge for the procedure requested. Providers are paid for authorized services according to the Department of Health and Family Services's (DHFS) *Terms of Provider Reimbursement.*

### Element 21 - Total Charge

Enter the anticipated total charge for this request.

### Element 22 - Billing Claim Payment Clarification Statement

An approved authorization does not guarantee payment. Payment is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment is not to be made for services initiated prior to approval or after authorization expiration. Payment is in accordance with Medicaid payment methodology and policy. If the recipient is enrolled in a Medicaid-contracted managed care program at the time a prior authorized service is provided, Medicaid payment is allowed only if the service is not covered by the managed care program.

### Element 23 - Date

Enter the month, day, and year (in MM/DD/YY formate) the prior authorization request form was completed and signed.

### Element 24 - Requesting Provider's Signature

The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element. Providers must enter the requested start date after the requesting provider's signature.

***Do not enter any information below the signature of the requesting provider. This space is used by Medicaid consultant(s) and analyst(s).***

## Appendix 9
## Sample Prior Authorization Therapy Attachment
## (Occupational Therapy)

Mail To:
E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

**PA/TA**

**THERAPY ATTACHMENT**
(Physical- Occupational-Speech Therapy)

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

**RECIPIENT INFORMATION**

| ① LAST NAME | ② FIRST NAME | ③ MIDDLE INITIAL | ④ MEDICAL ASSISTANCE ID NUMBER | ⑤ AGE |
|---|---|---|---|---|
| Recipient | Ima | A | 1234567890 | 3 |

**PROVIDER INFORMATION**

| ⑥ THERAPIST'S NAME AND CREDENTIALS | ⑦ THERAPIST'S MEDICAL ASSISTANCE PROVIDER NUMBER | ⑧ THERAPIST'S TELEPHONE NUMBER |
|---|---|---|
| I.M. Performing, P.T. | 12345678 | ( XXX ) XXX XXXX |

⑨ I.M. Referring/Prescribing
REFERRING/PRESCRIBING PHYSICIAN'S NAME

A. Requesting: ☒ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

B. Total time per day requested: 45 minutes
Total Sessions per week requested: 2x per week
Total number of weeks requested: 20 wks.

C. Provide a description of the recipient's diagnosis and problems including date of onset.

Female has a diagnosis of cerebral palsy. She also has a seizure disorder and exhibits delays in all areas of development.
Onset birth.

**D. Brief Pertinent History:**

Female is a twin, born at 24.5 wks. gestation. She was hospitalized for 4 months following birth. She was ventilator-dependent for 8 weeks. Recipient resides at home with twin brother, parents, and 2 older siblings. Seizures are currently controlled with _____ (Medication). Vision and hearing tested in _____ (MM/YY) and judged to be WNL. She wears bilateral night splints and bilateralAFOs. Family has mobility base with positioning and bathing adaptations.

| | Location | Date | Problem Treated |
|---|---|---|---|
| **E. Therapy History:** | | | |
| **PT** | XYZ | 1/2/XX to 1/11/XX | LE ROM<br>Muscle tone<br>Trunk central<br>Positioning |
| **OT** | XYZ | 1/2/XX to 1/11/XX | UE ROM<br>Splinting<br>ADL<br>NDT |
| **SP** | N/A | | |

**F. Evaluations: (Indicate Dates/Tests Used/Results) (Provide Date of Initial Evaluation)**

Initial evaluation completed MM/DD/YY on PA #1234567

See attached evaluation completed _____(MM/DD/YY).

M-Team evaluation and IEP dated _____(MM/DD/YY) (most current) are attached.

**G. Describe progress in measurable/functional terms since treatment was initiated or last authorized:**

| MM/DD/YY | MM/DD/YY |
|---|---|
| 1. *Shoulder flexion*<br>Was ____*. | Now is____*. |
| 2. *Dressing*<br>Was able to lift and push through sleeve until wrist in 3 of 3 trials. | Now can push through sleeve to mid-forearm in 1 of 3 attempts. |
| 3. *Sidesit*<br>Right weight bear on forearm--Required physical assist to assume position and tolerate it for 15 seconds. | Requires no assistance to assume position and tolerates it for 45 seconds. |
| 4. *Tactile defensiveness*<br>Previously immediately withdrew both hands from rice, sand, pudding, and various fabrics when physically placed on texture. | Now tolerates left hand placement on terry cloth and pudding for 15 seconds in 4 of 4 trials. Right hand tolerates physical placement on felt for 10 seconds in 6 of 10 trials. |
| 5. *Transfer of cube - midline*<br>Was able to hold 1 inch cube in one hand. No observation of hands at midline. | Now hold 1 inch at midline, but does not release to transfer to other hand |

**H. Plan of Care (Indicate specific measurable goals and procedures to meet those goals).**

1. Long-term goal (LTG): Maintain/increase both shoulder ROM to encourage active participation in UE dressing in 6 months.
   Short-term objective (STO): Increase RUE shoulder flexion 120° so that the child can lift arms and push RUE through shirt sleeve in 2 of 3 attempts when shirt is presented (97535).

2. LTG: Demonstrate trunk elongation to maintain upright sitting for self-feeding in 8 months.
   STO: Sidesit R for trunk elongation/ R weight bear on forearm without assistance, to maintain for 1 minute (97112).

3. LTG: Decrease tactile sensitivity to allow participation in hand washing without aversive reaction within 1 year.
   STO: Will seek and tolerate tactilely challenging materials with both hands for a duration of 30 seconds in 2 of 4 trials (97770).

4. LTG: Increase bilateral hand use for functional grasp in finger feeding within 6 months.
   STO: Will improve function thumb/finger opposition to be able to transfer 1" cube from one hand to the other 2 out of 5 trials (97112).

**I. Rehabilitation Potential:**

Given gains made in tolerance to handling and successful reduction in muscle tone, continued progress toward functional self-help skills is demonstrated. Recommend continuing treatment in addition to school therapy which currently provides 30-minute consult only. Therapist has contacted on ____ (MM/DD/YY) and does so bimonthly. A notebook is exchanged. Carryover plan for family is also attached.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

**J.**

| | |
|---|---|
| *I. M. Referring* | *I. M. Performing, O.T.R.* |
| Signature of Prescribing Physician (A copy of the Physician's order sheet is acceptable) | Signature of Therapist Providing Treatment |
| MM/DD/YY | MM/DD/YY |
| Date | Date |

## Appendix 9a
## Prior Authorization Therapy Attachment Completion Instructions
## (Occupational Therapy)

Do not use this attachment to request a spell of illness; use the Prior Authorization Spell of Illness Attachment (PA/SOIA).

Timely determination of prior authorization is significantly increased by submitting thorough documentation when requesting prior authorization to extend treatment beyond 35 treatment days for the same spell of illness. Carefully complete the Prior Authorization Therapy Attachment (PA/TA) form, attach it to the Prior Authorization Request Form (PA/RF), and submit to:

Attn: Prior Authorization, Suite 88
EDS
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding the completion of the PA/RF and/or PA/TA may be directed to the fiscal agent's Policy/Billing Correspondence Unit. Telephone numbers are in Appendix 2 of Part A, the all-provider handbook.

*Recipient Information*:

### Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's current identification card.

### Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's current identification card.

### Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's current identification card.

### Element 4 - Recipient's Wisconsin Medicaid Identification Number
Enter the recipient's ten-digit identification number from the recipient's current identification card.

### Element 5 - Recipient's Numerical Age
Enter the age of the recipient in numerical form (e.g., 21, 45, 60, etc.).

*Provider Information*:

### Element 6 - Therapist's Name and Credentials
Enter the name and credentials of the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, enter the name of the supervising therapist.

### Element 7 - Therapist's Wisconsin Medicaid Provider Number
Enter the eight-digit provider number of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter the provider number of the supervising therapist. Rehabilitation agencies do not indicate a performing provider.

### Element 8 - Therapist's Telephone Number
Enter the telephone number, including area code, of the therapist who is providing the authorized service (performing provider). If the performing provider is a therapy assistant, enter the telephone number of the supervising therapist.

### Element 9 - Referring/Prescribing Physician's Name
Enter the name of the physician referring/prescribing evaluation/ treatment.

Use the remaining portion of this attachment to document the justification for the requested service.

1. Complete elements A through J.

2. Element E - Provide a brief past history based on available information.

   Element F - Provide the evaluation results (you may attach the therapy evaluation to comply with this requirement).

   Element I - Provide the recipient's perceived potential to meet therapy goals.

3. Read the 'Prior Authorization Statement' before signing and dating the attachment.

4. The attachment must be signed and dated by the primary therapist who is responsible for and participating in therapy services for the recipient. If the performing provider is a therapy assistant, the supervising therapist must sign the attachment.

   The request must be accompanied by a physician's signature (a copy of the physician's order sheet dated within 90 days of its receipt by the fiscal agent indicating the physician's signature is acceptable). If the required documentation is missing from the request form, the request is returned to the provider requesting the required information.

5. Refer to Section III- E of this handbook for additional attachments that may be required.